Memorandum

Date NOV 13

From Janet Rehnquist
Inspector General

Subject Medicare Inpatient Hospital Prospective Payment System Transfers Incorrectly Reported as Discharges (A-06-00-00041)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

Attached is the Department of Health and Human Services, Office of Inspector General's (OIG) final audit report entitled, "Medicare Inpatient Hospital Prospective Payment System Transfers Incorrectly Reported as Discharges." The objectives of our review were to: (1) identify incorrectly reported prospective payment system (PPS) transfers in Medicare PPS inpatient hospital claims posted to the Centers for Medicare & Medicaid Services's (CMS) National Claims History (NCH) file between January 1, 1992 and June 30, 2000 and (2) determine whether data trends indicated that overpayments resulting from incorrectly reported PPS transfers decreased.

Hospitals incorrectly reporting PPS transfers as discharges and fiscal intermediaries (FI) failing to detect and correct these errors has been a concern of OIG and CMS for a number of years. Previous OIG or joint OIG and CMS efforts in this area resulted in over $219 million in recoveries.

In this review, we identified over 153,000 claims for incorrectly reported PPS transfers that were posted to CMS's NCH between January 1, 1992 and June 30, 2000. The potential overpayments related to these transfers totaled nearly $233 million. The 153,000 incorrectly reported transfers and the $233 million in related potential overpayments consisted of the following:

- 79,000 incorrectly reported PPS transfers resulting in overpayments and 74,000 incorrectly reported PPS transfers that did not result in overpayments; and

- $163.9 million of overpayments suitable for administrative recovery through FIs and $69.1 million of overpayments which are currently the subject of investigative initiatives.

Our examination of the 153,000 incorrectly reported PPS transfers showed that the number of incorrectly reported PPS transfers and resulting potential overpayments trended downward since 1992. Our analysis showed that hospitals incorrectly reported an average of 1,132 PPS transfers per month in 1992 with this average decreasing to about 495 per month in 1999.

Notwithstanding these decreases, hospitals continued to incorrectly report PPS transfers and FIs continued to pay PPS transfers as discharges. Through discussions with officials from CMS, FIs, and hospitals, we identified several reasons which may have contributed to this ongoing problem. These included misapplication of the PPS transfer payment policy by CMS regional offices and FIs; problems with computer systems interfaces at hospitals; and breakdowns in communication between hospitals' medical and billing staffs.

Although the number of incorrectly reported PPS transfers and the resulting overpayments decreased in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000, problems still continue. We believe that recovery of the $163.9 million in potential overpayments for incorrectly reported PPS transfers needs to begin. In addition, we believe that CMS should provide FIs with instructions to ensure consistent recovery of overpayments.

Accordingly, we recommended that CMS:

1. Issue instructions to and work with FIs to initiate the collection of the $163.9 million in potential overpayments identified to date;

2. Issue clarifying instructions or bulletins to FIs and hospitals to reiterate that a PPS transfer: (a) is defined as an admission to a PPS hospital on the day of discharge from another PPS hospital; (b) is a reimbursement policy applied after the stay is determined to be medically necessary; and (c) applies unless the hospital substantiates an independent intervening event justifying that the stay should be paid as a discharge rather than a transfer; and

3. Instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment to assure that PPS transfers are properly reported and that improperly reported PPS transfers are detected and corrected as called for in the PPS transfer policy.

The CMS generally concurred with our recommendations. Specifically, CMS concurred with our recommendation related to the collection of potential overpayments, but stated they will initially limit the recovery effort to the last 4 years in order to comply with the cost report reopening period designated in regulations 42 CFR 405.750. We continue to believe that the recovery of all overpayments for incorrectly reported PPS transfers should be pursued as diligently as in the past and should not be limited to the 4-year recovery period. We are prepared to assist CMS as it begins its recovery actions.

The CMS also concurred with our recommendation to issue clarifying instructions on the PPS transfer policy to FIs and hospitals. Lastly, although CMS agreed that additional steps need to be taken to identify improperly reported hospital transfers, they did not concur with our recommendation to instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment for PPS transfers. Instead, CMS is proposing to create a biannual data run to identify inappropriate transfers and require FIs to

make appropriate adjustments. While we agree that this action may help ensure that improper transfer claims are appropriately adjusted, we also believe that effective procedures implemented by FIs and hospitals could detect these improper claims prior to payment. We summarized CMS's comments and our response in the CONCLUSION section of the report. The CMS's entire response is included as APPENDIX F to our report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendation within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-06-00-00041 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM TRANSFERS INCORRECTLY REPORTED AS DISCHARGES

JANET REHNQUIST
Inspector General

NOVEMBER 2001
A-06-00-00041

EXECUTIVE SUMMARY

BACKGROUND

A prospective payment system (PPS) transfer occurs when a patient is admitted to a PPS hospital on the same day that he/she is discharged from a different PPS hospital. When a PPS transfer occurs, payment to the hospital from which the patient is transferred is based on a per diem methodology. If the transferring PPS hospital incorrectly reports the transfer as a discharge, it receives the full diagnosis related group payment, which is often more than the per diem payment for a transfer. In this review, the transferring hospital would have received a lesser payment about 52 percent of the time had it reported a transfer rather than a discharge.

Hospitals that do not accurately report PPS transfers have been a concern of both the Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) for many years. Shortly after the implementation of PPS, OIG began work to determine whether PPS hospitals properly adapted to the new rules governing payment for PPS transfers. In 1988, OIG issued a report where it determined that PPS hospitals had not taken steps to properly report PPS transfers. In 1992, following a successful pilot project in Region VI, OIG and CMS initiated a nationwide PPS transfer recovery project. The pilot and nationwide recovery projects resulted in about $219 million in Medicare recoveries.

Based on OIG's work, CMS implemented claims processing edits or alerts to identify incorrectly reported PPS transfers and provided fiscal intermediaries (FI) with an opportunity to prevent or correct overpayments. In November 1990, CMS issued a program memorandum reiterating to FIs that the admission of a patient into a PPS hospital on the same day the patient was discharged from a different PPS hospital is a transfer. The program memorandum provided FIs with instructions on how to process adjustments to claims for incorrectly reported PPS transfers. It also instructed FIs to advise PPS hospitals in their jurisdictions of the PPS transfer policy and of each hospital's responsibility to take steps necessary to correctly code PPS transfers.

OBJECTIVES

The objectives of our current review were to (1) identify incorrectly reported PPS transfers in Medicare PPS inpatient hospital claims posted to CMS's National Claims History (NCH) file between January 1, 1992 and June 30, 2000 and (2) determine whether data trends indicated that overpayments resulting from incorrectly reported PPS transfers decreased.

SUMMARY OF FINDINGS

We identified over 153,000 claims for incorrectly reported PPS transfers which were posted to CMS's NCH file between January 1, 1992 and June 30, 2000. The potential overpayments related to these transfers totaled nearly $233 million. The 153,000 incorrectly reported transfers and the $233 million in related potential overpayments consisted of the following:

- 79,000 incorrectly reported PPS transfers resulting in potential overpayments and 74,000 incorrectly reported PPS transfers that did not result in overpayments; and

- $163.9 million of potential overpayments suitable for administrative recovery through FIs and $69.1 million of potential overpayments which are currently the subject of investigative initiatives.

Our examination of the 153,000 incorrectly reported PPS transfers showed that the number of incorrectly reported PPS transfers and resulting potential overpayments trended downward since the 1992 joint OIG/CMS recovery project. Our analysis showed that hospitals incorrectly reported an average of 1,132 PPS transfers per month in 1992 with this average decreasing to about 495 per month in 1999. For this period, we also found that: (1) the monthly average overpayment for incorrectly reported PPS transfers fell from $3 million in 1992 to $1.3 million in 1999 and (2) hospitals were most likely to incorrectly report a PPS transfer as either a discharge to the patient's home (43.50 percent) or a transfer to a non-PPS hospital (32.27 percent). APPENDICES A through E contain both graphs of the data and our analysis of various PPS transfer payment data discussed in our report.

Notwithstanding the decreases described above, hospitals continued to incorrectly report PPS transfers and FIs continued to pay PPS transfers as discharges. Through discussions with officials from CMS, FIs, and hospitals, we identified several reasons which may have contributed to this ongoing problem. These included misapplication of the PPS transfer payment policy by CMS regional offices and FIs; problems with computer systems interfaces at hospitals; and breakdowns in communication between hospitals' medical and billing staffs.

CONCLUSIONS AND RECOMMENDATIONS

Although the number of incorrectly reported PPS transfers and the resulting overpayments decreased in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000, problems still continue. We believe that a number of factors involving the CMS regional offices, FIs, and hospitals contribute to the continuation of incorrectly reported PPS transfers, and that substantiation of the root causes is necessary in order for corrective action to be effective.

We believe that recovery of the $163.9 million in potential overpayments for incorrectly reported transfers needs to begin. In addition, we believe that CMS should provide FIs with instructions to ensure consistent recovery of the potential overpayments.

Accordingly, we recommended that CMS:

1. Issue instructions to and work with FIs to initiate the collection of the $163.9 million in potential overpayments identified to date;

2. Issue clarifying instructions or bulletins to FIs and hospitals to reiterate that a PPS transfer: (a) is defined as an admission to a PPS hospital on the day of discharge from another PPS hospital; (b) is a reimbursement policy applied after the stay is determined to be medically necessary; and (c) applies unless the hospital substantiates

an independent intervening event justifying that the stay should be paid as a discharge rather than a transfer; and

3. Instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment to assure that PPS transfers are properly reported and that improperly reported PPS transfers are detected and corrected as called for in the PPS transfer policy.

The CMS generally concurred with our recommendations. Specifically, CMS concurred with our recommendation related to the collection of potential overpayments, but stated they will initially limit the recovery effort to the last 4 years in order to comply with the cost report reopening period designated in regulations 42 CFR 405.750. We continue to believe that the recovery of all overpayments for incorrectly reported PPS transfers should be pursued as diligently as in the past and should not be limited to the 4-year recovery period. We are prepared to assist CMS as it begins its recovery actions.

The CMS also concurred with our recommendation to issue clarifying instructions on the PPS transfer policy to FIs and hospitals. Lastly, although CMS agreed that additional steps need to be taken to identify improperly reported hospital transfers, they did not concur with our recommendation to instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment for PPS transfers. Instead, CMS is proposing to create a biannual data run to identify inappropriate transfers and require FIs to make appropriate adjustments. While we agree that this action may help ensure that improper transfer claims are appropriately adjusted, we also believe that effective procedures implemented by FIs and hospitals could detect these improper claims prior to payment. We summarized CMS's comments and our response in the CONCLUSION section of the report. The CMS's entire response is included as APPENDIX F to our report.

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INTRODUCTION

BACKGROUND

A prospective payment system (PPS) with payment based on discharges was adopted for Medicare Part A inpatient services in hospitals not excluded from PPS with hospital cost reporting periods beginning on or after October 1, 1983. The PPS hospitals are paid for discharges and the amount is determined by the assigned diagnosis related group (DRG). However, transfers between hospitals paid under PPS are not considered discharges and are paid based on a per diem rate. The per diem methodology provides for payment amounts computed from the DRG based payment. Payment to the transferring hospital may not exceed the full prospective amount (i.e., the payment for a discharge).

In implementing the Medicare Part A PPS, the Centers for Medicare & Medicaid Services (CMS) promulgated 42 CFR 412.4. Section 412.4 (b) which sets forth the basic rules for patient transfers states:

> "A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the discharge is made under any of the following circumstances:
>
> (1) From a hospital to the care of another hospital that is —
>
> (i) Paid under the prospective payment system; or
>
> (ii) Excluded from being paid under the prospective payment system because of participation in an approved Statewide cost control program…."

Since 1983, two significant changes were incorporated into 42 CFR 412.4:

- payment of two per diems for the first day for transfers occurring on or after October 1, 1995; and
- the inclusion of 10 specific post-acute care DRGs as PPS transfers if the patient receives specified post-acute care on or after October 1, 1998.

The CMS contracts with fiscal intermediaries (FI) which are responsible for receiving, processing, and paying Medicare hospital claims. The FIs are required to determine the correct payment amount for each inpatient hospital claim based on applicable Medicare law, regulation, and CMS policy.

In November 1990, CMS issued a program memorandum reiterating to FIs that the admission of a patient into a PPS hospital on the same day the patient was discharged from a different PPS hospital is a transfer. As such, the transferring PPS hospital was to be paid a per diem amount appropriate to the date the patient left that hospital. The program memorandum provided

FIs with instructions on how to process adjustments to claims for incorrectly reported PPS transfers. It also instructed FIs to advise PPS hospitals in their jurisdictions of the PPS transfer policy and of each hospital's responsibility to take steps necessary to correctly code PPS transfers.

Shortly after the implementation of PPS, the Office of Inspector General (OIG) began work to determine whether PPS hospitals properly adapted to the rules governing payment for PPS transfers. From the earliest OIG report through the current report, OIG determined that PPS hospitals were not always properly reporting PPS transfers.

Following a successful pilot project in Region VI, OIG and CMS initiated the first nationwide PPS transfer recovery project. The pilot and nationwide recovery projects resulted in approximately $219 million in Medicare recoveries related to incorrectly reported PPS transfers. Additional OIG work identified corrective actions that, if implemented, were estimated to save Medicare another $8 million.

Based on OIG's work, CMS implemented claims processing edits or alerts to identify incorrectly reported PPS transfers and provide FIs with an opportunity to prevent or correct overpayment situations. The CMS also issued the November 1990 program memorandum, described above.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our current PPS transfer review were to: (1) identify incorrectly reported PPS transfers in Medicare PPS inpatient hospital claims posted to CMS's National Claims History (NCH) file between January 1, 1992 and June 30, 2000 and (2) determine whether data trends indicated that overpayments resulting from incorrectly reported PPS transfers decreased.

The objectives of our review did not require the review of any internal controls. To accomplish our objectives we:

- obtained and analyzed Medicare Part A PPS data for claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000;

- determined the number of incorrectly reported PPS transfers in the Medicare Part A claims posted to CMS's NCH file between the period January 1, 1992 and June 30, 2000;

- identified potential overpayments associated with the incorrectly reported PPS transfers contained in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000;

- analyzed trends in the number of, and overpayments resulting from, PPS transfers contained in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000;

- analyzed trends in the incorrectly reported PPS transfers when two different FIs were involved in the payment process; and

- analyzed why incorrectly reported PPS transfers continue to be a problem despite ongoing correction efforts.

In addition to the steps performed to accomplish our objectives, we relied on information developed during other OIG assignments to provide the basis for forming an opinion as to the reasons hospitals continue to incorrectly report PPS transfers as discharges, and FIs continue to pay these transfers as discharges. The information we relied on was obtained through:

- interviews with hospital officials and reviews of medical records for patients incorrectly reported as discharged, when the patients were admitted to another PPS hospital on the same day;

- discussions with FI staff regarding FI procedures applied to incorrectly reported PPS transfers which the FI attributed to CMS regional office (RO) instructions or guidance, and review of FI provider files related to hospitals that had problems with correctly reporting PPS transfers; and

- discussions with CMS staff.

Our audit was made in accordance with generally accepted government auditing standards. Most of the field work related to this review was performed in OIG's Region VI, Baton Rouge field office.

FINDINGS AND RECOMMENDATIONS

We identified over 153,000 claims for incorrectly reported PPS transfers which were posted to CMS's NCH file between January 1, 1992 and June 30, 2000. The potential overpayments related to these incorrectly reported PPS transfers totaled nearly $233 million. The incorrectly reported transfers and the related potential overpayments consisted of the following:

- 79,000 incorrectly reported PPS transfers resulting in potential overpayments and 74,000 incorrectly reported PPS transfers that did not result in overpayments[1]; and

- $163.9 million of potential overpayments suitable for administrative recovery through FIs and $69.1 million of potential overpayments which are currently the subject of investigative initiatives.

[1]The total payment for a PPS transfer is limited to the amount payable had the patient been discharged. Therefore, incorrectly reported transfers with lengths of stay longer than that used to determine the per diem amount do not result in overpayments.

Our analysis of the incorrectly reported PPS transfers in claims posted to NCH between January 1, 1992 and June 30, 2000, showed a substantial decrease in both the rate of occurrence and in the resulting overpayments through the period. As reflected in graphs 1 and 2 of APPENDIX E, the period began with 24,128 incorrectly reported transfers in 1992 and ended with 14,869 incorrectly reported PPS transfers in 1999.[2] Through the period, incorrectly reported transfers resulting in overpayments fell from 13,581 in 1992 to 5,940 in 1999. The amount of potential overpayments made to hospitals incorrectly reporting transfers also fell from $36,026,722 in 1992 to $15,938,295 in 1999. More complete data regarding the incorrectly reported transfers and resulting potential overpayments are presented in APPENDICES A and B.

The decrease in the number of incorrectly reported PPS transfers and the associated overpayments showed that improvements are taking place. However, the downward trend did not appear to coincide with the prior recovery project or issuance of additional instructions and clarifications to PPS hospitals. The downward trend became most apparent following OIG's inclusion of additional PPS transfer work in its Fiscal Year 1995 work plan and the involvement of investigative agencies in reviews of incorrectly reported PPS transfers.

Notwithstanding the decreases described above, hospitals continued to incorrectly report PPS transfers. Through information gathered in other audit assignments, we identified several reasons that may have contributed to this ongoing problem. These included misunderstandings related to the purpose and application of the PPS transfer policy and systems weaknesses.

POTENTIAL CAUSES FOR CONTINUATION OF THE INCORRECTLY REPORTED PPS TRANSFERS

In general, the continuation of hospitals incorrectly reporting PPS transfers and FIs paying these transfers as discharges may be caused by confusion about the purpose and application of the PPS transfer policy, at both hospitals and FIs, and systems weaknesses.

Misunderstanding of PPS Transfer Policy and Systems Weaknesses at Hospitals

Hospital medical records were reviewed in other OIG work involving these, as well as other, incorrectly reported PPS transfer issues. During these reviews, OIG staff found sufficient information in the medical records to conclude that the hospitals involved could have, in most cases, correctly reported the PPS transfer. In the review of medical records, at least one hospital had knowledge of or participated in the transfer in more than 90 percent of the cases reviewed. Hospital staff, who also reviewed the medical records, agreed that the medical records provided sufficient information at the time the claims were filed, or shortly thereafter, to have submitted the claims as PPS transfers rather than PPS discharges.

Hospital officials provided three primary reasons as to why they had incorrectly reported PPS transfers as discharges. These were:

[2]Our analysis is based on January 1, 1992 through December 31, 1999 because the data for 2000 was far from complete and its inclusion would present an inaccurate impression of the data's true trend.

- problems in interfaces within hospital computer systems, most notably between the medical records and billing components, which led to the submission of claims as discharges rather than transfers;

- assumptions that the receiving hospital is excluded from PPS based on the type of patients accepted and the services rendered. Hospitals often reported transfers to long-term care hospitals using the discharge code 05 (discharged/transferred to another type of institution) without confirming that the receiving hospital was, in fact, excluded from PPS. For example, after receiving OIG's listing of incorrectly reported PPS transfers, a compliance officer at one hospital contacted the receiving hospital to verify that the hospital was not under PPS. However, the compliance officer found that the receiving hospital had only recently requested exemption from PPS. In light of this mistaken assumption, hospital staff agreed that they should have confirmed the receiving hospital's Medicare status prior to submitting their claim to Medicare; and

- breakdowns in communication between hospitals' medical and billing staffs. In some cases, the hospital's rate of incorrectly reported PPS transfers declined significantly, or ceased, after internal reviews detected the problem and steps were instituted to prevent the incorrect reporting of PPS transfers. However, as part of their efforts to improve communications between hospital departments, none of the hospitals which detected problems had taken steps to determine the significance of the problem and repay Medicare for the overpayments received.

Misunderstanding of PPS Transfer Policy and Systems Weaknesses at FIs

We also identified several instances where FIs' misunderstandings of the PPS transfer policy contributed to incorrectly reported transfers. Generally, these instances related to the reimbursement aspects of the PPS transfer policy being mistakenly overshadowed by medical necessity concerns, or the resolution of incorrectly reported PPS transfers referred by OIG to investigative agencies.

In one example, based on the correspondence reviewed**,** it was clear that the FI had followed the edit instruction and changed the hospital's reported discharge to a transfer and paid the claim accordingly. However, when the hospital protested, the FI referred both the discharge and the subsequent same day admission to the peer review organization (PRO). The FI requested that the PRO determine whether an inappropriate or premature discharge occurred at the first hospital, and whether the care at the second hospital was necessary. Although the PRO had not completed its work at the time of our review, FI staff stated that, if the PRO found both hospitalizations to be medically necessary, the FI would pay both claims as hospital discharges. Based on the instructions in the November 1990 program memorandum, we believe the appropriate action would have been for the FI to remind the hospital of CMS's policy regarding discharges and admissions on the same day and that reimbursement as a transfer was correct.

In a second example, we believe that the FI mistakenly resolved incorrectly reported PPS transfers declined by investigative agencies. These incorrectly reported PPS transfers were to be returned to OIG for recovery of potential overpayments. However, in at least one

declination, the investigative agency referred the incorrectly reported PPS transfers to the FI for administrative recovery. In an attempt to prevent duplication of recovery, we contacted the FI. In discussing the transfers, the FI stated that very few of the transfers required adjustment. The FI stated that it had reviewed the medical records and determined that most of the patients were subsequently admitted to hospitals located on the other side of the State, and therefore, both claims should be and were paid as a discharge.

We disagreed with the FI. First, the discharges reviewed by the FI met the definition of a transfer, as set forth in the November 1990 program memorandum. Second, the FI did not review the medical records to determine whether the first hospital had knowledge of or participated in the transfer. We believe it is necessary for the FI to consider knowledge of, and participation in, the transfer in order to determine how to appropriately resolve the incorrectly reported PPS transfer.

PPS Systems Weaknesses

We also believe that systems weaknesses within FIs claims payment systems or between FIs and the Common Working File (CWF) system may have contributed to FIs continuing to pay PPS transfers as discharges. The systems weaknesses may have contributed to payments for incorrectly reported transfers, despite the edits or alerts for detecting incorrectly reported PPS transfers that were in both systems.

CONCLUSIONS AND RECOMMENDATIONS

Although the number of incorrectly reported PPS transfers and the resulting overpayments decreased in claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000, problems still continue. We believe that a number of factors involving the CMS ROs, FIs, and hospitals contributed to the continuation of incorrectly reported PPS transfers, and that substantiation of the root causes is necessary in order for corrective action to be effective.

We believe that recovery of the $163.9 million in potential overpayments for incorrectly reported transfers needs to begin. In addition, we believe that CMS should provide FIs with instructions to ensure consistent recovery of the potential overpayments.

Accordingly, we recommended that CMS:

1. Issue instructions to and work with FIs to initiate the collection of the $163.9 million in potential overpayments identified to date;

2. Issue clarifying instructions or bulletins to FIs and hospitals to reiterate that a PPS transfer: (a) is defined as an admission to a PPS hospital on the day of discharge from another PPS hospital; (b) is a reimbursement policy applied after the stay is determined to be medically necessary; and (c) applies unless the hospital substantiates an independent intervening event justifying that the stay should be paid as a discharge rather than a transfer; and

3. Instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment to assure that PPS transfers are properly reported and that improperly reported PPS transfers are detected and corrected as called for in the PPS transfer policy.

CMS COMMENTS

In their written response to our draft report, CMS generally agreed with our recommendations. Specifically, CMS agreed to issue instructions to and work with FIs to initiate the collection of potential overpayments. However, CMS plans to limit the recovery period to the last 4 years, in order to comply with the cost report reopening period provided for in 42 CFR 405.750. With respect to the potential overpayments beyond the 4-year period, CMS plans to research the overpayment data to determine whether any of the overpayments qualify for recovery under the regulations.

The CMS also concurred with our recommendation to issue clarifying instructions to FIs and hospitals regarding the PPS transfer policy. The CMS stated that they will issue an instruction to FIs reiterating the PPS transfer policy and ask that FIs include an educational article in their next provider bulletin reinforcing the need for proper coding procedures.

Further, CMS agreed that additional steps need to be taken to identify improperly reported hospital transfers. However, CMS did not agree with our recommendation to instruct FIs and hospitals to review all internal procedures and processes to assure that PPS transfers are properly detected, reported, and corrected. The CMS stated that because of the timing of processing claims from facilities involved in the improper transfers, FIs are only able to correct the improper transfers on a post-payment basis. Therefore, CMS believes it would be preferable and administratively more efficient to institute a process creating a biannual data run to identify the inappropriate transfers. The CMS would then forward identified claims to FIs for investigation, and where appropriate, adjustment bills would be created by FIs.

OIG RESPONSE

We are prepared to assist CMS as it begins its recovery actions to collect potential overpayments identified to date. However, we do not agree with CMS's plan to initially limit recoveries to the most recent 4-year period. While we recognize the recovery limitations imposed in regulations 42 CFR 405.750, we do not believe they apply to the collection of potential overpayments related to inappropriately reported PPS transfers. The CMS has continuously provided instructions to PPS hospitals addressing improper transfers. In spite of these instructions, many PPS hospitals have continued to submit inappropriate PPS transfer claims for reimbursement. In the past, CMS has been supportive of OIG's efforts to recover Medicare funds from those hospitals that have not adhered to CMS guidance regarding the proper way to report and claim reimbursement to PPS transfer claims. Until now, CMS had not limited those recoveries to the 4-year period imposed in 42 CFR 405.750. We believe that the recovery of all overpayments for incorrectly reported PPS transfers should be pursued as diligently as in the past, and not be limited to the 4-year recovery period.

With respect to CMS's plans to create a biannual data run to identify inappropriate transfers on a post-payment basis, we agree that such action may help ensure that Medicare claims for improper transfers are appropriately adjusted. However, we also believe that if both FIs and hospitals established effective procedures many improper PPS transfers could be detected prior to Medicare's payment for these inappropriate claims.

OTHER MATTERS

At CMS's request, we performed additional data analyses to determine whether: (1) certain patient discharge/transfer status codes were more commonly used on claims containing incorrectly reported PPS transfers; and (2) the involvement of different FIs in the claims payment process impacted the number of and potential overpayments resulting from incorrectly reported PPS transfers.

Discharge/Transfer Status Codes

Most of the claims posted to CMS's NCH file between January 1, 1992 and June 30, 2000, which contained an incorrectly reported PPS transfer, contained one of the two following discharge codes:

- Code (01) discharged to home or self-care — 66,647 (43.50 percent of all incorrectly reported PPS transfers) and $87,278,006 in overpayments (37.47 percent of all overpayments); and

- Code (05) discharged/transferred to another type of institution — 49,441 (32.27 percent of all incorrectly reported PPS transfers) and $86,957,189 in overpayments (37.33 percent of all overpayments).

In 1992, hospitals incorrectly reported PPS transfers as discharges to home or self-care, code (01), 11,552 times resulting in $15,911,424 in overpayments. In 1999, the last full year of data analyzed, hospitals incorrectly reported PPS transfers as discharges using code (01) 5,616 times resulting in potential overpayments of $5,269,948.

In 1992, hospitals incorrectly reported PPS transfers as discharges/transfers to another type of institution, code (05), 8,612 times resulting in $14,051,508 in overpayments. In 1999, hospitals incorrectly reported PPS transfers as discharges using code (05) 4,272 times resulting in potential overpayments of $5,337,099.

During the same time period in which the number of PPS transfers incorrectly reported as discharge codes (01) and (05) decreased, increases occurred in the usage of three other codes:

- Code (03) — discharged/transferred to a skilled nursing facility;

- Code (04) — discharged/transferred to an intermediate care facility; and

- Code (06) — discharged/transferred to home in care of a home health agency.

With the exception of discharge code (03), which accounted for 14.36 percent of all incorrectly reported PPS transfers and 14.43 percent of all overpayments between January 1, 1992 and June 30, 1999, hospitals did not make extensive use of these three codes to incorrectly report PPS transfers. Misuse of the code for reporting patients discharged or transferred to a skilled nursing facility occurred 21,999 times in the period and resulted in overpayments of $33,614,923. The occurrence of the codes and the amounts of overpayment by code are shown in APPENDIX B.

PPS Transfer Payments Involving Two FIs

We also examined claims related to the incorrectly reported PPS transfers to determine whether transfers were more likely to go undetected when different FIs paid the transferring and receiving hospitals. We found that 59,656 or 38.94 percent of the 153,214 undetected and uncorrected incorrectly reported PPS transfers occurred when different FIs paid the hospitals involved in transferring and receiving the patient. Of the $232,920,529 in overpayments for incorrectly reported PPS transfers, $92,798,399 or 39.84 percent occurred where different FIs paid the hospitals involved in transferring and receiving the patient. The rate that incorrectly reported PPS transfers went undetected and uncorrected when different FIs paid the hospitals involved in transferring and receiving the patient ranged from 11.40 percent to 100 percent.

Summary details regarding the involvement of multiple FIs in incorrectly reported PPS transfers are presented in APPENDICES C and D.

SCHEDULE OF INCORRECTLY REPORTED PPS TRANSFERS[1]
January 1,1992 through June 30, 2000

Occurrence of Incorrectly Reported PPS Transfers With an Overpayment (OP)

Period	Start	End	Months	With OP	Monthly Average	Percentage Change
1992	01/01/92	12/31/92	12	13,581	1,132	
1993	01/01/93	12/31/93	12	13,512	1,126	0.51 ↓
1994	01/01/94	12/31/94	12	12,897	1,075	4.55 ↓
1995	01/01/95	12/31/95	12	10,089	841	21.77 ↓
1996	01/01/96	12/31/96	12	7,294	608	27.70 ↓
1997	01/01/97	12/31/97	12	7,404	617	1.51 ↑
1998	01/01/98	12/31/98	12	6,246	521	15.64 ↓
1999	01/01/99	12/31/99	12	5,940	495	4.90 ↓
2000	01/01/00	06/30/00	6	2,190	365	
			102	79,153	776	

Occurrence of Potential Overpayments for Incorrectly Reported PPS Transfers

Period	Start	End	Months	OP	Monthly Average	Percentage Change
1992	01/01/92	12/31/92	12	$36,026,722	$3,002,227	
1993	01/01/93	12/31/93	12	40,543,316	3,378,610	12.54 ↑
1994	01/01/94	12/31/94	12	39,815,173	3,317,931	1.80 ↓
1995	01/01/95	12/31/95	12	32,652,476	2,721,040	17.99 ↓
1996	01/01/96	12/31/96	12	21,540,779	1,795,065	34.03 ↓
1997	01/01/97	12/31/97	12	22,137,397	1,844,783	2.77 ↑
1998	01/01/98	12/31/98	12	18,581,542	1,548,462	16.06 ↓
1999	01/01/99	12/31/99	12	15,938,295	1,328,191	14.23 ↓
2000	01/01/00	06/30/00	6	5,684,826	947,471	
			102	$232,920,526	$2,283,535	

[1]Upward pointing arrows indicate the trend rate is increasing or getting worse and downward pointing arrows indicate that the trend rate is decreasing or getting better. For example, in 1993 the rate of occurrence of incorrectly reported PPS transfers improved by 0.51 percent while the overpayment for the incorrectly reported PPS transfers exceeded the 1992 overpayment by 12.54 percent. Percent of change omitted for 2000 because the period is incomplete.

SCHEDULE OF CODES USED TO INCORRECTLY REPORT PPS TRANSFERS
January 1,1992 through June 30, 2000
BY DISCHARGE CODE INCORRECTLY USED BY HOSPITALS[2]

Code 01 Discharged to Home or Self Care (routine discharge)

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	5,020	6,532	11,552		$15,911,423	
1993	4,025	5,780	9,805	15.12↓	15,061,264	5.34↓
1994	3,890	5,967	9,857	0.53↑	15,755,271	4.61↑
1995	3,488	4,908	8,396	14.82↓	13,056,761	17.13↓
1996	3,651	3,130	6,781	19.24↓	7,465,031	42.83↓
1997	3,960	3,024	6,984	2.99↑	7,314,155	2.02↓
1998	3,296	2,380	5,676	18.73↓	5,552,179	24.09↓
1999	3,397	2,219	5,616	1.06↓	5,269,947	5.08↓
2000	1,183	797	1,980		1,891,971	
	31,910	34,737	66,647		$87,278,002	

Code 03 Discharged/Transferred to a Skilled Nursing Facility

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	1,098	1,190	2,288		$ 3,334,417	
1993	1,097	1,251	2,348	2.62↑	4,459,831	33.75↑
1994	1,123	1,403	2,526	7.58↑	4,740,600	6.30↑
1995	1,186	1,341	2,527	0.04↑	5,414,964	14.23↑
1996	1,268	1,142	2,410	4.63↓	3,634,181	32.89↓
1997	1,652	1,188	2,840	17.84↑	4,230,393	16.41↑
1998	1,870	1,137	3,007	5.88↑	3,810,711	9.92↓
1999	1,887	1,096	2,983	0.80↓	3,025,845	20.60↓
2000	686	384	1,070		963,975	
	11,867	10,132	21,999		$33,614,917	

[2]Upward pointing arrows indicate the trend rate is increasing or getting worse and downward pointing arrows indicate that the trend rate is decreasing or getting better. For example, in 1993 the rate at which hospitals incorrectly reported patients discharged to home (code 01) dropped by 15.12 percent over 1992 and the overpayments made because hospitals incorrectly reported patients discharged to home when the patient went on to another PPS hospital declined by 5.34 percent. Percent of change omitted for 2000 because the period is incomplete.

SCHEDULE OF CODES USED TO INCORRECTLY REPORT PPS TRANSFERS
January 1,1992 through June 30, 2000
BY DISCHARGE CODE INCORRECTLY USED BY HOSPITALS

Code 04 Discharged/Transferred to an Intermediate Care Facility

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	317	458	775		$1,015,864	
1993	318	447	765	1.29↓	1,374,264	35.28↑
1994	290	489	779	1.83↑	1,798,283	30.85↑
1995	319	533	852	9.37↑	1,740,446	3.22↓
1996	485	455	940	10.33↑	1,439,154	17.31↓
1997	503	432	935	0.53↓	1,259,129	12.51↓
1998	532	404	936	0.11↑	1,131,368	10.15↓
1999	593	429	1,022	9.19↑	1,184,846	4.73↑
2000	248	177	425		478,259	
	3,605	3,824	7,429		$11,421,613	

Code 05 Discharged/Transferred to Another Type of Institution (e.g., jails, supervised residential facilities)

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	3,618	4,994	8,612		$14,051,508	
1993	3,727	5,617	9,344	8.50↑	17,642,986	25.56↑
1994	2,777	4,565	7,342	21.43↓	15,730,901	10.84↓
1995	1,894	2,807	4,701	35.97↓	10,205,996	35.12↓
1996	2,270	2,136	4,406	6.28↓	7,503,408	26.48↓
1997	2,485	2,382	4,867	10.46↑	7,921,255	5.57↑
1998	2,234	1,963	4,197	13.77↓	6,619,490	16.43↓
1999	2,425	1,847	4,272	1.79↑	5,337,098	19.37↓
2000	1,006	694	1,700		1,944,544	
	22,436	27,005	49,441		$86,957,186	

SCHEDULE OF CODES USED TO INCORRECTLY REPORT PPS TRANSFERS
January 1,1992 through June 30, 2000
BY DISCHARGE CODE INCORRECTLY USED BY HOSPITALS

Code 06 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization

CY	Without OP	With OP	Total Errors	Percentage Change	OP	Percentage Change
1992	425	237	662		$ 718,443	
1993	374	271	645	2.57↓	886,266	23.36↑
1994	343	285	628	2.64↓	769,953	13.12↓
1995	386	290	676	7.64↑	883,244	14.71↑
1996	499	261	760	12.43↑	668,542	24.31↓
1997	493	231	724	4.74↓	552,398	17.37↓
1998	514	213	727	0.41↑	483,363	12.50↓
1999	505	193	698	3.99↓	422,625	2.57↓
2000	163	83	246		166,627	
	3,702	2,064	5,766		$5,551,461	

SCHEDULE OF OCCURRENCE WHEN TRANSFERRING AND RECEIVING HOSPITALS PAID BY SAME OR BY TWO INTERMEDIARIES

FI	Total Errors	Same FI Pay Both	Other FI Pay Receiving	Percent of Error When Second FI Involved
00010	3,786	2,948	838	22.13%
00011	2	0	2	100.00%
00020	1,262	712	550	43.58%
00030	2,891	1,690	1,201	41.54%
00040	8,842	5,690	3,152	35.65%
00050	138	67	71	51.45%
00060	1,044	700	344	32.95%
00070	718	163	555	77.30%
00090	8,683	6,026	2,657	30.60%
00101	4,312	3,325	987	22.89%
00121	4,003	2,725	1,278	31.93%
00123	3,882	3,260	622	16.02%
00130	4,723	3,770	953	20.18%
00131	624	380	244	39.10%
00140	1,844	1,375	469	25.43%
00150	1,901	1,451	450	23.67%
00160	4,159	3,251	908	21.83%
00180	1,032	846	186	18.02%
00181	538	368	170	31.60%
00190	1,152	849	303	26.30%
00200	2,430	1,885	545	22.43%
00210	3,299	2,923	376	11.40%
00220	1,523	917	606	39.79%
00230	4,428	2,806	1,622	36.63%
00231	1,663	1,197	466	28.02%
00241	384	281	103	26.82%
00250	356	228	128	35.96%
00260	691	326	365	52.82%
00270	1,152	724	428	37.15%
00280	9,137	6,403	2,734	29.92%
00290	594	377	217	36.53%
00308	6,128	4,055	2,073	33.83%

SCHEDULE OF OCCURRENCE WHEN TRANSFERRING AND RECEIVING HOSPITALS PAID BY SAME OR BY TWO INTERMEDIARIES

FI	Total Errors	Same FI Pay Both	Other FI Pay Receiving	Percent of Error When Second FI Involved
00310	2,976	2,312	664	22.31%
00320	604	373	231	38.25%
00332	3,168	2,467	701	22.13%
00340	1,643	1,317	326	19.84%
00350	1,385	1,110	275	19.86%
00351	214	58	156	72.90%
00362	1,669	555	1,114	66.75%
00363	4,531	3,113	1,418	31.30%
00370	1,018	796	222	21.81%
00380	1,774	1,124	650	36.64%
00390	2,855	1,536	1,319	46.20%
00400	3,303	1,837	1,466	44.38%
00401	48	28	20	41.67%
00410	751	658	93	12.38%
00423	4,554	2,378	2,176	47.78%
00430	2,273	1,332	941	41.40%
00450	2,494	2,142	352	14.11%
00452	1,767	1,199	568	32.14%
00453	267	70	197	73.78%
00460	342	130	212	61.99%
00468	1,120	910	210	18.75%
17120	170	124	46	27.06%
50333	1,759	222	1,537	87.38%
51051	3,156	371	2,785	88.24%
51070	615	324	291	47.32%
51100	234	0	234	100.00%
51140	626	41	585	93.45%
51390	2,001	915	1,086	54.27%
52280	18,576	4,398	14,178	76.32%
Totals	153,214	93,558	59,656	38.94%

SCHEDULE OF POTENTIAL OVERPAYMENTS WHEN TRANSFERRING AND RECEIVING HOSPITALS PAID BY SAME OR BY TWO INTERMEDIARIES

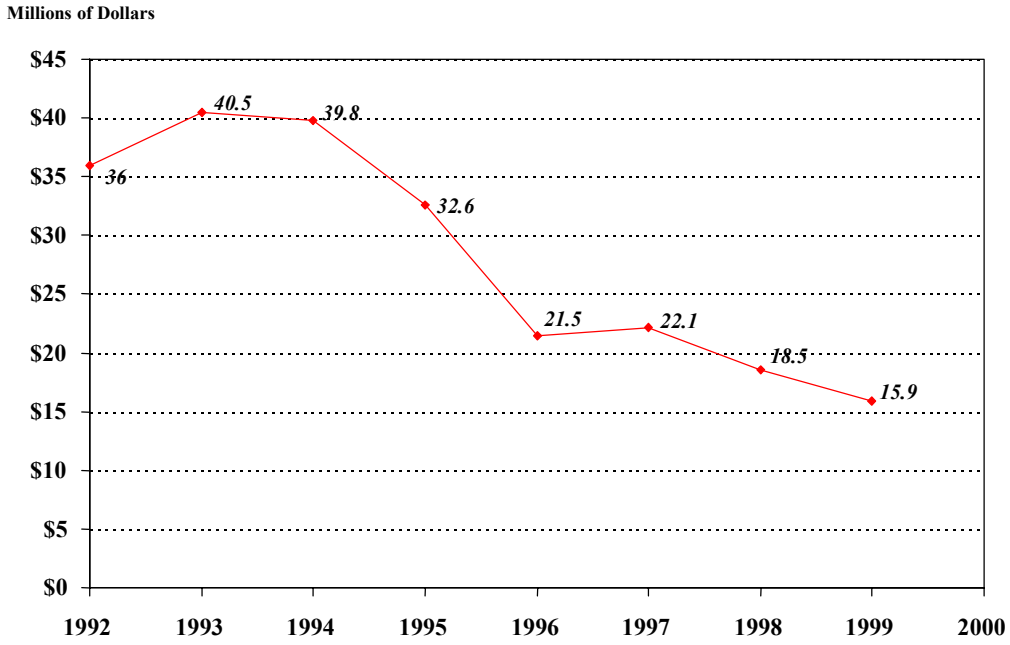
FI	Total Overpayments	Same FI Pay Both	Other FI Pay Receiving	Percent of Overpayment Two Intermediaries
00010	$ 4,537,017	$ 3,436,115	$ 1,100,902	24.26%
00011	506	0	506	100.00%
00020	1,580,716	796,061	784,655	49.64%
00030	4,976,125	3,040,607	1,935,518	38.90%
00040	20,266,406	12,777,687	7,488,719	36.95%
00050	208,849	82,056	126,793	60.71%
00060	1,372,821	951,509	421,312	30.69%
00070	1,038,719	212,295	826,424	79.56%
00090	13,928,578	9,774,730	4,153,848	29.82%
00101	5,190,046	4,030,698	1,159,348	22.34%
00121	8,009,711	6,047,634	1,962,077	24.50%
00123	6,597,420	4,475,860	2,121,560	32.16%
00130	7,361,136	6,134,672	1,226,464	16.66%
00131	732,520	473,574	258,946	35.35%
00140	1,990,349	1,508,990	481,359	24.18%
00150	2,546,773	1,843,420	703,353	27.62%
00160	5,523,113	4,210,255	1,312,858	23.77%
00180	1,431,941	1,125,035	306,906	21.43%
00181	855,673	530,015	325,658	38.06%
00190	2,796,382	1,531,131	1,265,251	45.25%
00200	4,376,506	3,305,572	1,070,934	24.47%
00210	5,208,578	4,530,187	678,391	13.02%
00220	2,657,692	1,417,014	1,240,678	46.68%
00230	4,602,492	2,903,022	1,699,470	36.92%
00231	2,809,490	2,102,856	706,634	25.15%
00241	720,629	433,500	287,129	39.84%
00250	480,916	296,841	184,075	38.28%
00260	831,934	464,035	367,899	44.22%
00270	1,802,441	1,067,143	735,298	40.79%
00280	9,461,983	6,369,592	3,092,391	32.68%
00290	1,213,726	714,669	499,057	41.12%
00308	7,820,756	5,583,603	2,237,153	28.61%

SCHEDULE OF POTENTIAL OVERPAYMENTS WHEN TRANSFERRING AND RECEIVING HOSPITALS PAID BY SAME OR BY TWO INTERMEDIARIES

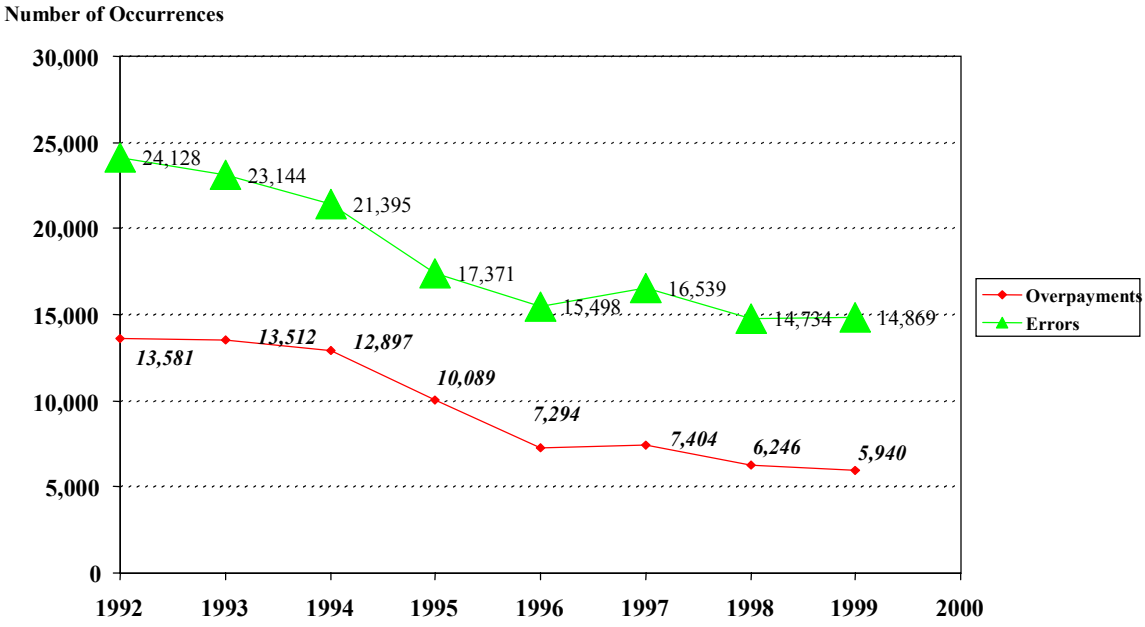
FI	Total Overpayments	Same FI Pay Both	Other FI Pay Receiving	Percent of Overpayment Two Intermediaries
00310	4,715,880	3,618,247	1,097,633	23.28%
00320	755,296	436,482	318,814	42.21%
00332	5,906,519	4,887,103	1,019,416	17.26%
00340	2,367,029	1,956,452	410,577	17.35%
00350	1,948,467	1,656,107	292,360	15.00%
00351	384,314	124,043	260,271	67.72%
00362	2,279,321	672,206	1,607,115	70.51%
00363	6,488,473	4,315,315	2,173,158	33.49%
00370	1,215,623	951,082	264,541	21.76%
00380	2,296,781	1,415,039	881,742	38.39%
00390	4,520,407	2,519,018	2,001,389	44.27%
00400	5,012,463	2,914,987	2,097,476	41.85%
00401	50,214	39,826	10,388	20.69%
00410	1,364,693	1,220,732	143,961	10.55%
00423	6,139,727	3,509,271	2,630,456	42.84%
00430	4,320,010	2,611,812	1,708,198	39.54%
00450	2,827,322	2,249,266	578,056	20.45%
00452	2,982,704	1,081,883	1,900,821	63.73%
00453	261,144	69,255	191,889	73.48%
00460	569,624	196,188	373,436	65.56%
00468	416,750	342,409	74,341	17.84%
17120	283,142	235,555	47,587	16.81%
50333	2,130,688	351,411	1,779,277	83.51%
51051	6,486,312	792,057	5,694,255	87.79%
51070	1,060,148	540,322	519,826	49.03%
51100	715,249	0	715,249	100.00%
51140	1,151,415	65,042	1,086,373	94.35%
51390	3,391,084	1,565,443	1,825,641	53.84%
52280	27,947,755	7,615,168	20,332,587	72.75%
Totals	$232,920,498	$140,122,099	$92,798,399	39.84%

APPENDIX E

Incorrectly Reported PPS Transfers
Overpayments Per Year
January 1, 1992 through December 31, 1999



Incorrectly Reported PPS Transfers
Number of Occurrences Per Year
January 1, 1992 through December 31, 1999



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: AUG 14 2001

TO: Michael F. Mangano
Acting Inspector General
Office of Inspector General

FROM: Ruben J. King-Shaw, Jr.
Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Inpatient Hospital Prospective Payment System Transfers Incorrectly Reported as Discharges* (A-06-00-00041)

We appreciate the opportunity to review the above-mentioned OIG draft report. Reducing the amount of incorrectly reported prospective payment system (PPS) transfers and the resulting potential for overpayments has been a concern of the Centers for Medicare & Medicaid Services (CMS). The CMS implemented claims processing edits and issued program memorandums to fiscal intermediaries (FIs) in order to identify and prevent incorrectly reported PPS transfers and overpayments. As OIG noted, since 1992, the number of incorrect PPS transfers per month has declined from an average of 1,132 to about 495 in 1999.

The OIG's study continues to find hospitals incorrectly reporting PPS transfers and the FIs continuing to pay PPS transfers as discharges. Correspondingly, OIG recommends CMS issue instructions and work with the FIs to initiate the collection of potential overpayments. Furthermore, OIG recommends CMS reissue instructions to FIs and hospitals to reiterate PPS transfer policy, and instruct FIs and hospitals to review all internal procedures and processes for proper claims submission. The CMS agrees with these OIG recommendations and will take corrective action to address these issues. However, we do not concur with the OIG's third recommendation to instruct FIs and hospitals to review all internal procedures and processes for proper claims submission. We believe a biannual data run to identify inappropriate transfers would be more preferable.

With regard to the specific OIG recommendations, our comments are as follows:

OIG Recommendation

CMS should issue instructions to and work with FIs to initiate the collection of the $163.9 million in potential overpayments identified to date.

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS). We are exercising fiscal restraint by exhausting our stock of stationery.

Page 2- Michael F. Mangano

CMS Response
We concur. The CMS will initially limit the recovery period to the last 4 years in order to comply with the reopening period designated in regulations 42 CFR 405.750. The CMS will research the overpayment data beyond the 4 years to determine whether any of the overpayments qualify for recovery under the regulations. Additionally, CMS will issue a program memorandum directing the FIs to make recoveries for the last 4 years. We appreciate the OIG providing the FIs with the listing that identifies the coding errors and the corresponding overpayments.

OIG Recommendation
CMS should issue clarifying instructions or bulletins to FIs and hospitals to reiterate that a PPS transfer: (a) is defined as an admission to a PPS hospital on the day of discharge from another PPS hospital; (b) is a reimbursement policy applied after the stay is determined to be medically necessary; and (c) applies unless the hospital substantiates an independent intervening event justifying that the stay should be paid as a discharge rather than a transfer.

CMS Response
We concur. We will issue an instruction to contractors reiterating our PPS transfer policy and ask that they include an educational article in their next provider bulletin reinforcing the need for proper coding procedures.

OIG Recommendation
CMS should instruct FIs and hospitals to review all internal procedures and processes related to claims submission or payment to assure that PPS transfers are properly reported and that improperly reported PPS transfers are detected and corrected as called for in the PPS transfer policy.

CMS Response
We agree with OIG that additional steps need to be taken to identify improperly reported hospital transfers. However, we do not agree with OIG's proposed solution. At the time FIs receive the "discharge claim" from the first facility, FIs do not know that a transfer has taken place. This information becomes apparent when the claim from the second facility is later received indicating a transfer, rather than a discharge. Thus, the FIs are only able to rectify these occurrences on a post-pay review basis.

We believe that it would be preferable and administratively more efficient for CMS to institute a process creating a biannual data run to identify the inappropriate transfers. The CMS will then forward identified claims to FIs for investigation, and, where appropriate, adjustment bills would be created by the FIs.